Appendix 6
Prior Authorization Psychotherapy Attachment (PA/PSYA) Completion Instructions

Since having to return a prior authorization (PA) request for corrections or additional information can delay the prompt approval and delivery of services to a recipient, providers should ensure that all clerical information is correctly entered on the Prior Authorization Request Form (PA/RF) and that all clinical information necessary to document that the service is medically necessary is included. Carefully complete the Prior Authorization Psychotherapy Attachment (PA/PSYA), attach it to the PA/RF, and submit to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Questions regarding the completion of the PA/RF and/or the PA/PSYA may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

General Instructions

The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to understand the necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form.

When submitting the first PA request for a particular individual, please fill out both pages. For continuing PA on the same individual, it is not necessary to rewrite the first page, unless new information has caused a change in any of the information on this page (e.g., a different diagnosis, belief that intellectual functioning is, in fact, significantly below average). When there has been no change in page one information, please submit a photocopy of page one along with the updated page two. Medical consultants reviewing the PA requests have a file containing the previous requests, but they must base their decisions on the clinical information submitted, so it is important to present all current relevant clinical information. For example, a depressed person may overeat or eat too little, or may sleep a lot or very little; therefore, recording simply that the recipient is depressed does not present the relevant clinical picture. The documentation should include details on the signs and symptoms the recipient presents due to the diagnosis.

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that previous providers notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

Recipient Information

Element 1 — Last Name
Enter the recipient's last name. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — First Name
Enter the recipient's first name. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — MI
Enter the recipient's middle initial.

Element 4 — Medical Assistance Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

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Element 5 — Age
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

Provider Information

Element 6 — Performing Provider Name
Enter the name of the therapist who will be providing treatment. Circle or enter discipline (credentials) of the therapist who will be providing treatment at the right of Element 8 (e.g., I.M. Provider, MD., or I.M. Provider Ph.D.).

Element 7 — Performing Provider # (not required)

Element 8 — Performing Provider's Telephone Number
Enter the telephone number, including area code, of the performing provider.

Element 9 — Supervising Provider's Name
Enter the name of the physician or psychologist who is supervising the treatment if the performing provider is a Master's-level therapist.

Element 10 — Supervising Provider's Number (not required)

Element 11 — Prescribing Provider's Name
Enter the name of the physician who wrote the prescription for psychotherapy.

Element 12 — Prescribing Provider's Number
Enter the eight-digit Medicaid provider identification number of the physician who wrote the prescription for psychotherapy.

Documentation

A — Diagnosis
Enter the diagnosis codes and descriptions from the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), using all five axes.

B — Date Treatment Began
Date of first treatment by this provider.

C — Diagnosed By
Indicate the procedure(s) used to make the diagnosis.

D — Consultation
Indicate whether there was a consultation done with respect to the recipient's diagnosis and/or treatment needs. Indicate why the consultation was needed.

E — Result(s) of Consultation
Summarize the results of this consultation or attach a copy of the consultant's report.

F — Presenting Symptoms
Enter the presenting symptoms and indicate the degree of severity. This information may be provided as a part of an intake summary that may be attached to this request form.

G-H — Intellectual Functioning
Indicate whether intellectual functioning is significantly below average (e.g., an I.Q. below 80). If "yes," indicate the I.Q. or intellectual functioning level.

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I — Historical Data
This information may be submitted in the form of an intake summary, case history, or mental status exam as long as all information relevant to the request for treatment authorization is included.

J — Present GAF (DSM)
Enter the global assessment of functioning scale score from the most recent version of the DSM. For continuing PA requests, indicate whether the recipient is progressing in treatment, using measurable indicators when appropriate.

K — Present Mental Status/Symptomatology
Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is not acceptable to send progress notes which do not summarize the progress to date.

L — Updated/Historical Data
For continuing requests, indicate any new information about the recipient's history which may be relevant to determine the need for continued treatment.

M — Treatment Modalities
Indicate the treatment modalities to be used.

N — Number of Minutes Per Session
Indicate the length of session for each modality.

O-P — Frequency of Requested Sessions and Total Number of Sessions Requested
If requesting sessions at a higher frequency, please indicate why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

Example: A provider requests 15 hours of treatment over a 12-week period. The recipient attends a one and one-half hour group every other week (six groups for a total of nine hours). There are one-hour weekly individual sessions for four weeks and every other week for the following four weeks (six individual sessions for a total of six hours).

Q — Psychoactive Medication
Indicate all the medications the recipient is taking which may affect the recipient's symptoms that are being treated. Indicate whether a medication review has been done in the past three months.

R — Rationale for Further Treatment
Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is helping.

S — Goals/Objectives of Treatment
Summarize current goals/objectives of treatment. A treatment plan may be attached in response to this item.

T — Steps to Termination
Indicate how you are preparing the recipient for termination. When available, indicate a planned date of termination.

U — Family Members
Adequate justification is required if an individual provider provides services to more than one family member in individual psychotherapy.

Signature of Performing Provider

Wisconsin Medicaid requires the performing provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Recipient Signature

Signature indicates the signer has read the form. Signature is optional.

Signature of Supervising Provider

Signature required only if the performing provider is not a physician or psychologist.

Other Required Information

In addition to the above information, Wisconsin Medicaid requires the following to process the PA request:

- Attach a copy of the signed and dated prescription for psychotherapy*. The initial prescription must be dated within three months of receipt by Wisconsin Medicaid. Subsequent prescriptions must be dated within 12 months of receipt by Wisconsin Medicaid.

* If the performing provider is a physician, a prescription need not be attached.